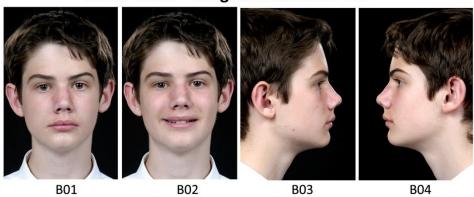
Study number:		

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MEDICAL PHOTOGRAPHY FORM

Α1	ID Number			
A2	Name			
А3	Date of Birth			Place for Cleft identification sticker if available
	Hospital Number			
A5	Today's date/			
	Facial photographs obtained			
B01	Face AP	Yes	1	No
B02	Face AP smiling	Yes	1	No
B03	Face right lateral	Yes	1	No
B04	Face left lateral	Yes	1	No 2
B05	Lips/ nose AP	Yes	1	No 2
B06	Lips/ nose AP (lips whistling/ blowing)	Yes	1	No
B07	Lips/ nose worm's eye view (WEV)	Yes	1	No
	Intra oral photographs obtained			
B08	Teeth right oblique	Yes	1	No
B09	Teeth AP	Yes	1	No
B10	Teeth left oblique	Yes	1	No
B11	Palate (hard)	Yes	1	No
B12	Teeth upper arch (mirror)	Yes	1	No
B13	Teeth overjet	Yes	1	No
Tha	nk you for filling this in – please state your			
C1 N	lame:			
C2 [Designation:			
C3 E	mail:			
C4 (Contact number:			
C5 <i>A</i>	any additional information that you think wou	ld be he	lpful is	s most welcome.

Facial views Magnification ratio 1:8



Lip/ nose views Magnification ratio 1:4



Intra-oral views Magnification ratio 1:2



Contact for medical photography:

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